IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8873

June 30, 2006

G. David Chinchurreta, Administrator
Sunbridge Retirement & Rehabilitation for Nampa
2609 Sunnybrook Drive
Nampa, ID 83686

Provider #: 135102

Dear Mr. Chinchurreta:

On **June 16, 2006**, a Recertification survey was conducted at Sunbridge Retirement & Rehabilitation for Nampa by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 13, 2006**. Failure to submit an acceptable PoC by **July 13, 2006**, may result in the imposition of civil monetary penalties by **August 2, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 21, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 21, 2006**. A change in the seriousness of the deficiencies on **July 21, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 21, 2006** includes the following:

Denial of payment for new admissions effective **September 16, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 16, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 16, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 13, 2006**. If your request for informal dispute resolution is received after **July 13, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135102	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/16/2006
NAME OF PROVIDER OR SUPPLIER **SUNBRIDGE FOR NAMPA**	STREET ADDRESS, CITY, STATE, ZIP CODE **2609 SUNNYBROOK DR NAMPA, ID**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 164	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, it was determined the facility failed to provide personal privacy and confidentiality of the resident's personal and clinical records. This was true for 1 of 1 random resident (random resident #12). Findings include: On 6/13/06 at 8:05 am, a medication cart was observed in the main hallway outside the dining room. A medication administration book was observed on top of the cart, open to random resident #12's medication administration record. The cart was located in a high traffic area, visible to staff, residents and the public. The licensed nurse using the cart was in the dining room assisting residents with breakfast. The cart was left unattended from 8:05 am until 8:14 am, at which time another licensed nurse noticed the open book and closed it.
F 167	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135102	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/16/2006

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 167	Continued From Page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not have the most recent annual fire and life safety survey results readily accessible to 1 of 1 floors for residents. This could potentially effect 10 of 10 (#1 - 10) sampled residents, all other residents at the facility, and family members or personal representatives for the residents. The findings include: Idaho Department of Health & Welfare Informational Letter #2003-01, stated, "...I believe that when facilities are required at F167 to post a notice and make the most recent survey available to residents, this means the most recent initial survey, or the most recent recertification survey, or the most recent complaint survey. Included in the most recent initial survey and the most recent recertification survey, is the LSC [Life Safety Code]...With this federal guidance in mind, this agency will begin to check the survey posting with the expectation that the LSC survey will be posted along with the other required surveys. This will begin effective with the date of this letter..." The letter was dated 1/13/03. On 6/12/06 at 12:40 pm, the survey book containing the most recent annual survey, was observed in a wall mounted cubby. The fire and life safety annual survey results were not in this book. The MDS nurse was asked at 1:35 pm on 5/12/06, why the fire and life safety survey results were not in with the other surveys. The MDS nurse looked in the book and acknowledged that the fire and life safety results were not in the book and indicated that they should have been. At this time the MDS nurse called down to the maintenance office and found out the maintenance supervisor had the survey results in his office.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/30/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. BUILDING _____ B. WING _____	06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNBRIDGE FOR NAMPA	2609 SUNNYBROOK DR NAMPA, ID 83686

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F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Lory Dayley, RD LD, Team Coordinator Kim Heuman, RN Lea Stoltz, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	This facility does not necessarily agree with all of the written deficiencies but is submitting the following Plan of Correction related to the cited deficiencies. This Plan of Correction constitutes our Credible Allegation of Compliance. RECEIVED JUL 13 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B. David Churchurreta | TITLE: Administrator | (X6) DATE: July 12, 2006

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to review and revise the care plan for 1 of 10 sampled residents (#4). The findings include: Resident #1 was admitted to the facility on 4/11/06 with the diagnoses of a hip fracture, anemia, hematuria, and ischemic heart disease. The resident's care plan, dated 4/11/06, documented, "Potential for falls...bed alarm. W/C [wheel chair] alarm.." The resident's care plan, dated 4/24/06, documented, "Potential for altered nutrition...To main DR [dining room] all meals 1) foam handles on utensils 2) Brown mug [with] lid."	F 280		

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F 280	Continued From page 2 From 6/12/06 though 6/14/06 the resident was observed several times without alarms on her bed or wheel chair, and did not have foam handles on her utensils or use a brown mug. On 6/14/06 at 7:50 am, the MDS nurse was informed of the surveyor's observations of resident #4 not having the alarms on her bed or wheel chair, not being provided with foam handles on her utensils or brown mug with a lid, and the intervention listed in the resident's care plan. At that time the MDS nurse followed the surveyor to observe the resident. The MDS nurse acknowledged the resident did not have these interventions in place. The MDS nurse indicated that she would find out about these items and get back to the surveyor. On 6/14/06 at 8:00 am, the MDS nurse indicated that the alarms and the adaptive equipment were no longer being used because the resident felt undignified with this these things in place. The MDS nurse acknowledged that the care plan needed to be updated. At 11:40 am the MDS nurse provided an updated care plan dated 6/14/06 with the items discontinued.	F 280	F-280 1. Care plans have been updated for residents #1 and #4. 2. Residents with any change in their plan of care would have the potential to be affected by this deficient practice. Care plans will be reviewed and updated by July 21, 2006. 3. Changes in the plan of care are initiated either by a physician's order or by nursing and/or dietary in weekly Action Team Meetings. The physician's orders are reviewed daily by the DNS. Any changes that would affect the plan of care will be entered within 72 hrs. 4. DNS will conduct random checks of 5-6 resident care plans monthly for two consecutive quarters and a written report made to the QA Committee. 5. July 21, 2006.	

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F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not ensure sanitary conditions were maintained in the following areas: 1) food contact surfaces clean and sanitized, 2) food contact surfaces smooth and free of pits 3) labeling large containers of food, 4) non food contact surfaces clean and sanitized, 5) maintaining the freezer, and 6) storage of bowls. This had the potential to affect 100 % of the residents who ate in the facility, including 10 of 10 sampled residents (#1-10). Findings include: 1. On 6/13/06 at 10:00 am, the microwave in the activity room was observed to have dried food debris on the inside top and sides and a sticky substance on the inside bottom. The bread machine in the activity room had hard pieces of bread on the inside of the bread pan. At this same time, the microwave in the hall next to the refrigerator was observed to have dried food debris on the inside top and sides. At this time the MDS nurse observed these pieces of equipment with the surveyor and acknowledged the equipment needed to be cleaned. The MDS nurse was not sure how long it had been since the bread machine was used or how often the microwaves were cleaned. At 11:35 am, the MDS nurse indicated the microwaves were cleaned by housekeeping once a day and that she was not	F 371		

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F 371	Continued From page 4	F 371		

sure about the bread machine.

On 6/14/06 at 12:45 pm, the MDS nurse provided the surveyor with the owner's manual for the bread machine. The bread machine owner's manual on page 12 under "Clean After Each Use" documented, "...2. The bread pan and knead bar must be cleaned after each use to ensure proper performance..."

Chapter 4, subsection 601.11 of the 2005 Federal Food Code indicates,"(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted deposits and other soil accumulations..."

2. On 6/12/06 at 11:20 am, in the long term care kitchen and on 6/14/06 at 7:05 am, in the main kitchen, three large manual can openers were observed to have the coating missing off the blade, were no longer sharp at the tip, and had gouges in the blades. At this time, the dietary manager indicated she was not sure when the last time they were changed and acknowledged that the blades needed to be replaced.

Chapter 4, subsection 202.11 of the 2005 Federal Food Code indicates,"...(A) Multiuse Food-Contact Surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..."

3. On 6/12/06 at 11:20 am, in the main kitchen, a large container of flour, with the original package removed, was observed without a label. At this time, the dietary manager acknowledged the flour

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F 371	Continued From page 5 bin should have been labeled. Chapter 3, subsection 302.12 of the 2005 Federal Food Code indicates,"Working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food except that containers holding food that can be readily and unmistakably recognized such as dry pasta need not be identified." 4. On 6/12/06 at 11:20 am, in the long term care kitchen, a fan was observed on a shelf facing the trayline and covered in dust. During this same observation time in the main kitchen dishroom, a fan was observed facing the dirty and clean dishes and covered in dust. On 6/14/06 at 7:05 am, in the main kitchen dish room, the same fan was observed to be in the same location covered in dust. The dietary manager indicated the fans were cleaned once a month and acknowledged they had a build up of dust on them. Chapter 4, subsection 601.11 of the 2005 Federal Food Code indicates,"...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 5. On 6/12/06 at 11:20 am, the large walk-in freezer in the main dining room, was observed to have large icicles hanging from a pipe. The boxes of food and the floor under this pipe had ice accumulated on them. At this time, the dietary manager indicated she would find out what was going on with the freezer and would get back to	F 371		

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F 371	Continued From page 6 the surveyor. On 6/14/06 at 8:20 am, the dietary manager indicated the freezer needed to be defrosted, and that was the reason water was dripping from the pipe onto the boxes of food and floor and then freezing. Chapter 6, subsection 501.11 of the 2005 Federal Food Code indicates,"(A) The physical facilities shall be maintained in good repair." 6. On 6/14/06 at 7:35 am, in the long term care dish room, several stacks of medium size bowls were observed to be stored on a rack. The dishes were not covered or inverted. Chapter 4, subsection 903.11 of the 2005 Federal Food Code indicates,"...(B) Clean Equipment and Utensils shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted..."	F 371	F 371 1. The Nutritional Services Director has corrected all the deficiencies as listed on the CMS-2567 immediately at the time of the survey. 2. All residents have the potential to be affected by the deficient practices listed. All dietary staff will be inserviced as to the deficient practices and methods to prevent the deficiencies in the future. 3. Nutritional Services Director will monitor on a daily random basis for all listed issues on this survey and continue the monitoring for two quarters. 4. Nutritional Services Director will submit a written report to the QA Committee. 5. July 21, 2006 ⟷	

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Lory Dayley, RD LD, Team Coordinator Kim Heuman, RN Lea Stoltz, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	RECEIVED JUL 13 2006 FACILITY STANDARDS	
C 124	02.100,03,c,viii viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract; This Rule is not met as evidenced by: Refer to F164 as it relates to privacy of resident records.	C 124	Please Refer to F 164	7-21-06

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C 325	Continued From page 1	C 325		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F 371 as it relates to storing, preparing, distributing, and serving food under sanitary conditions.	C 325	Please Refer to F 371	7-21-06
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F 280 as it relates to updating care plans.	C 782	Please Refer to F 280	7-21-06